REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE BOARD OF MEDICAL QUALITY ASSURANCE HAS MADE PROGRESS IN IMPROVING ITS DIVERSION PROGRAM: SOME PROBLEMS REMAIN

P-576

JUNE 1986

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JUNE 1986

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Thomas W. Hayes
Auditor General

June 19, 1986 P-576

Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the Board of Medical Quality Assurance's diversion program for rehabilitating physicians who suffer from alcoholism or drug abuse. Although the board has improved its oversight of the diversion program, the report indicates a need for increased routine monitoring of diversion program participants.

We conducted this audit to comply with Resolution Chapter 117, Statutes of 1985.

Respectfully submitted,

for THOMAS W. HAYES
Auditor General

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SUMMARY

RESULTS IN BRIEF

In 1982 and 1985, the Auditor General reported on the Board of Medical Quality Assurance's (board) diversion program for rehabilitating physicians who suffer from alcoholism, drug abuse, or physical or mental illness. Since our last report, the board has improved its procedures for reviewing participants who are not complying with their treatment plans. The board has also improved its oversight of the diversion program since the board's chief medical consultant, who supervises the program, now receives sufficient information to take the appropriate action to more effectively manage the program.

However, the board still needs to improve its routine monitoring of participants. Compliance officers, who are required to monitor participants' progress in the diversion program, have inadequately monitored participants' compliance with their treatment plans. When compliance officers do not adequately monitor participants, the board's chances of detecting those participants who may be using drugs or alcohol are decreased. Therefore, in these cases, the board is not protecting the public's safety as effectively as it could.

BACKGROUND

The board is responsible for licensing the State's physicians and for enforcing provisions of the Medical Practice Act. As of December 31, 1985, the State had approximately 110,000 licensed physicians. In addition, in 1980 the board implemented the diversion program for physicians who suffer from alcoholism, drug abuse, or physical or mental illness. The purpose of the diversion program is to rehabilitate these physicians while protecting the health and safety of the public. In May 1986, the diversion program had approximately 218 participants.

PRINCIPAL FINDINGS

The Board Has Improved Its Procedures for Reviewing Participants Who Do Not Comply With Their Treatment Plans

In our 1982 and 1985 reports, we concluded that the diversion program manager did not appropriately review participants who did not comply with the terms of their treatment plans. However, since our last review, the board has improved the procedures for reviewing noncompliant participants. In our sample of 21 participants, we identified 5 who were not complying with their treatment plans, who were using or were suspected of using alcohol or drugs, or who had other problems that could affect their rehabilitation. A compliance officer or a facilitator for diversion group meetings appropriately reported each of these cases to the program manager. Each participant's case was reviewed; then, each participant was appropriately counseled.

Participants Are Not Adequately Monitored

According to the program manager, all participants should be visited at least once every two months, and these visits should be random, not scheduled. However, of the 21 participants in our sample, 17 (81 percent) participants were not visited for periods ranging from three to seven months. Furthermore, of the 21 participants in our sample, 14 required monthly urine samples. However, compliance officers did not collect urine samples from 10 (71 percent) of these participants. Compliance officers did not collect urine samples from these participants for periods ranging from two to four months. Finally, compliance officers are required to contact participants' condition monitors at least once every two months by phone or in person. Of the 21 participants in our sample,

14 had a condition monitor. Compliance officers did not make adequate contact with 12 (86 percent) of these condition monitors. Compliance officers did not contact these condition monitors for periods ranging from three to eight months.

Compliance Officers Are Not Adequately Supervised

The program manager does not check the accuracy of compliance officers' recordkeeping: he does not ensure that compliance officers obtain signed letters from condition monitors explaining the condition monitor's responsibilities, he does not ensure that compliance officers submit written reports that document visits to participants, nor does he ensure that urine samples that compliance officers report are documented by laboratory reports. The program manager also does not have a system to produce and follow up on specific reports identifying those participants whom compliance officers have not visited frequently enough, who have not had required urine samples collected, and whose condition monitors have not been contacted. According to the program manager, these deficiencies in monitoring participants have occurred because of personnel problems.

However, in May 1986, the program manager began implementing a computerized tracking system that will generate information that identifies participants who are inadequately monitored by compliance officers.

RECOMMENDATIONS

To improve the monitoring activities of its compliance officers, the board should do the following things:

- Clarify written program policy;

- Ensure that compliance officers understand all program policies and know how to keep accurate records;

- Verify the accuracy of compliance officers' recordkeeping; and

- Continue to use its computerized tracking system to identify deficiencies in monitoring activities.

AGENCY COMMENTS

The State and Consumer Services Agency concurs with the Auditor General's findings and recommendations concerning the Board of Medical Quality Assurance's diversion program. The board is presently implementing the report's recommendations. In addition, the board has recently adopted new policies to strengthen the monitoring of physicians and to protect the public's safety.

INTRODUCTION

The Board of Medical Quality Assurance (board) is responsible for licensing the State's physicians. As of December 31, 1985, the State had approximately 110,000 licensed physicians, including 37,901 physicians who have out-of-state addresses. The board is also responsible for enforcing the provisions of the Medical Practice Act and for investigating and disciplining physicians who violate the Medical Practice Act. In addition to its enforcement program, the board implemented a diversion program in 1980 to rehabilitate physicians who suffer from alcoholism, drug abuse, or physical or mental illness. The purpose of this program is to rehabilitate these physicians without endangering the health and safety of the public. As of May 1986, the diversion program had approximately 218 participants. (Appendix A presents information on these participants and past program participants.) The diversion program's budget of $529,431 for fiscal year 1985-86 comes primarily from licensing fees paid by physicians.

Participation in the diversion program is voluntary. Physicians enter the program because they want to, because the board has issued them a probationary (restricted) license, or because the board's enforcement program is investigating complaints against them. When the board's investigation determines that a physician is suffering from alcoholism, drug abuse, or physical or mental illness, investigators recommend the physician to the diversion program. If the physician enters the program, the enforcement program halts the

investigation. The investigation is resumed, however, if the physician quits the diversion program before successfully completing it or if the diversion program terminates the physician from the program for failing to comply with the treatment plan. The treatment plan is an agreement, signed by the participant, listing the terms and conditions the participant must adhere to while in the diversion program.

In addition, in November 1985, the board adopted a policy requiring all participants entering the program to sign an agreement. This agreement allows the diversion program manager to turn over to the board's enforcement program all of a participant's records if the participant withdraws or is terminated from the program and a diversion evaluation committee determines the participant cannot practice medicine safely. In these cases, the participant's records will be used to pursue disciplinary action.

The board's five "diversion evaluation committees," each consisting of five members with expertise in alcoholism and drug abuse, evaluate physicians before they are accepted into the diversion program. When a diversion evaluation committee accepts a physician as a participant in the program, it assigns a member of the committee as a case consultant for the physician. The diversion evaluation committees design individual treatment plans for the rehabilitation of each participant. These treatment plans generally last for three to five years. In designing treatment plans, committees decide whether physicians should continue to practice medicine while undergoing

treatment, whether physicians need supervision while treating patients, and whether physicians need restrictions on their permits for prescribing drugs.

One of the main methods of treating participants in the diversion program is requiring them to attend group meetings, which occur twice a week. The group meetings, which are similar to support group meetings of Alcoholics Anonymous or Narcotics Anonymous, provide the participants with their most frequent contact with the diversion program. Facilitators, who conduct these meetings, assist the diversion program's staff in monitoring the participants' compliance with treatment plans. Facilitators observe the participants and report to the program manager if they suspect that participants have resumed using alcohol or drugs. Facilitators also report on the attendance of participants and may request that participants provide urine samples for testing.

The diversion program has four compliance officers located in different regions of the State. The compliance officers monitor participants' compliance with their treatment plans by visiting participants and by collecting urine samples for laboratory analyses to test for alcohol or drug use. Compliance officers must also submit reports to the program manager on the participants' progress in their rehabilitation. Some participants must also obtain "condition monitors," who assist compliance officers in monitoring participants' compliance with their treatment plans. These condition monitors

generally are physicians or supervisors who work in the same building as the participants, and they are responsible for observing the participants' condition while the participants practice medicine.

Furthermore, the program manager is responsible for supervising the monitoring of participants and for ensuring that participants comply with their treatment plans. In instances of serious noncompliance by participants, the program manager can instruct participants to stop treating patients for a specified period. The program manager can also refer participants to diversion evaluation committees for review. The committees can recommend treatment to participants or can terminate participants from the diversion program.

Previous Auditor General Reports Addressing the Board's Diversion Program

In August 1982 and January 1985, the Auditor General issued reports on the board's diversion program. Both reports concluded that participants were not adequately monitored and that participants who were not complying with significant terms and conditions of their treatment plans were not appropriately reviewed. In addition, our January 1985 report concluded that the board did not adequately supervise the diversion program. The Auditor General recommended, in part, that the board provide compliance officers with training in the diversion program's policies and procedures, improve the system of tracking compliance officers' monitoring, develop new guidelines for condition monitors, specify for the program manager the kinds of

noncompliance that warrant suspension and termination, develop a system to ensure that the program manager consults with diversion evaluation committees when participants violate significant terms and conditions of their treatment plans, and develop a reporting system to provide the board with enough information to supervise the diversion program. (Appendix B presents information on the status of the 35 participants who were included in the sample of cases analyzed in our 1985 report.)

SCOPE AND METHODOLOGY

The purpose of this review was to evaluate the board's management of its diversion program for physicians who suffer from alcoholism or drug abuse. We conducted this audit to comply with Resolution Chapter 117, Statutes of 1985, which requires the Auditor General to conduct an examination of the board's diversion program.

To evaluate the board's diversion program, we interviewed the board's chief medical consultant, diversion program staff, compliance officers, and facilitators for group meetings. We also attended a diversion group meeting and a diversion evaluation committee meeting. To determine how well the diversion program is monitoring its participants and what procedures program staff use to follow up on participants who are not complying with their treatment plans, we reviewed case files for a sample of 21 of the approximately 215 participants in the program as of February 1986. Although the diversion program accepts physicians who suffer from alcoholism, drug

abuse, or physical or mental illness, we limited our review to case files of physicians who were in the program because of alcoholism or drug abuse. Our review of files covers the period from July 1, 1985, through February 28, 1986.

ANALYSIS

THE BOARD OF MEDICAL QUALITY ASSURANCE'S DIVERSION PROGRAM NEEDS FURTHER IMPROVEMENT

The Board of Medical Quality Assurance (board) has improved its oversight of the diversion program for physicians since our audits in 1982 and 1985; however, further improvement is needed. Since our last report, the diversion program manager has improved the procedures for reviewing participants who do not comply with the significant terms and conditions of their treatment plans. In addition, the board has improved its overall supervision of the diversion program. However, the board still does not routinely monitor participants adequately.

Although compliance officers should make unscheduled visits to participants at least every two months, compliance officers did not visit 81 percent of the participants in our sample for periods ranging from approximately three months to seven months. Compliance officers also did not collect all the urine samples for 71 percent of the participants in our sample who required monthly urine samples. Finally, compliance officers did not contact participants' condition monitors as frequently as the diversion program's policy requires. If the board fails to ensure that compliance officers properly monitor their participants, then the board's chances of detecting those participants who may be using drugs or alcohol decreases; consequently, the board is not protecting the public's safety as effectively as it could be.

The Board Has Improved Its Oversight of the Diversion Program

Diversion program policy requires that compliance officers, facilitators, and condition monitors report their observations of participants who are not complying with their treatment plans to the diversion program's manager. It is the program manager's responsibility to deal with these instances of noncompliance. When participants significantly fail to comply with the terms and conditions of their treatment plans, the program manager should contact the participants' case consultants. The program manager may also recommend that participants be reviewed at a diversion evaluation committee meeting, or the program manager can instruct the participants to stop treating patients for a specified period. In addition, the program manager is responsible for sending information concerning instances of noncompliance to the board's chief medical consultant, who is responsible for overseeing the diversion program.

Our previous reports concluded that the diversion program manager did not appropriately review participants who did not comply with the significant terms and conditions of their treatment plans and that the board's chief medical consultant did not receive sufficient information to manage the program properly. However, in June 1985, the board hired a new program manager, and since our last review, the procedures for reviewing participants who do not comply with their treatment plans have been improved. In our sample of 21 participants, we identified 5 participants who, during the time of our review, were

not complying with their treatment plans, were using or were suspected of using drugs or alcohol, or had other problems that could affect their rehabilitation. Each of these participants was reported to the diversion program manager by either the participant's facilitator or the participant's compliance officer. In three of these cases, the program manager contacted case consultants to discuss a resolution of the participants' problems. In addition, 4 of the 5 participants were reviewed by diversion evaluation committees; the committees required two of the participants to enter live-in programs that treat persons suffering from alcohol or drug abuse, amended the treatment plan of one participant, and took no action in regard to the other participant. The program manager, the case consultant, the compliance officer, and the facilitator made a joint decision to have the participant who was not reviewed by a diversion evaluation committee take antabuse, a drug meant to discourage the use of alcohol.

The board's chief medical consultant received information concerning these participants and the resolution of their problems. The chief medical consultant uses this information to ensure that all cases of noncompliance are documented and to monitor the diversion program manager's resolution of cases involving significant noncompliance. The chief medical consultant also receives copies of treatment plans for all the participants, and he attends many of the meetings of the diversion evaluation committees to ensure that the board's policies relating to the diversion program are appropriately implemented.

The Board's Monitoring of Program Participants Is Inadequate

Compliance officers do not visit participants in the diversion program or collect urine samples from these participants as frequently as policy requires. In addition, compliance officers do not maintain adequate contact with the participants' condition monitors.

Compliance Officers Do Not Visit Participants as Frequently as Policy Requires

The program policy implemented in July 1985 requires compliance officers to visit participants on a priority basis. Participants who are assigned a high priority are visited monthly. These participants include physicians who are suspected of using drugs or alcohol, physicians who have missed several diversion group meetings, and physicians who are required to sign their treatment plans. Compliance officers are to visit other participants as time permits, but the program manager stated that all participants should be contacted at least every two months. Previous policy required monthly visits during the participants' first year in the program and bimonthly visits after the first year if the participants had made appropriate progress in the diversion program.

Program policy requires "face-to-face personal contact between the compliance officer and the program participant" during visits. In addition, the program manager stated that, whenever possible, visits

with participants should be made randomly and should not be scheduled and that visits should not generally take place at diversion group meetings. Compliance officers are required to prepare written reports documenting their visits for participants' case files.

We reviewed case files for 21 of the program's participants and determined that compliance officers did not visit 17 (81 percent) of these participants frequently enough.* Table 1 shows the longest time periods between the visits compliance officers made to the 21 participants whose cases we reviewed.

TABLE 1

FREQUENCY OF VISITS
COMPLIANCE OFFICERS MADE TO PARTICIPANTS

Number of Months With No Visit	Number of Participants	Percent
0 - 2	4	19%
3	7	33
4	4	19
5	2	10
6	1	5
7	3	14
Total	21	100%

*We did not count as visits those contacts compliance officers made at diversion group meetings or telephone calls compliance officers made to participants.

As indicated in Table 1, compliance officers did not visit 17 participants for periods ranging from approximately three months to seven months. For instance, one compliance officer visited 2 of the participants assigned to him only when the participants first signed their treatment plans. Then, he did not visit one of the participants for at least three months, and he did not visit the other participant for at least seven months. Furthermore, the same compliance officer made no personal visits to another participant from the time the participant entered the program on August 1, 1985, to the time our review ended nearly seven months later.

In addition, although the program manager has improved the procedures for reviewing participants who do not comply with their treatment plans, compliance officers are sometimes deficient in following up on these noncompliant participants because they do not visit the participants as often as they should. For example, although one participant was suspected of using alcohol on October 18, 1985, and the compliance officer visited him six days later, the compliance officer did not visit him again until January 15, 1986, nearly three months later. Another participant was suspected of using drugs on December 2, 1985, and his case was discussed at a diversion evaluation committee meeting. However, the compliance officer assigned to this participant did not visit the participant until February 6, 1986, over two months later. According to program policy, these participants should have been assigned a high priority and should have been visited monthly since they were suspected of using drugs or alcohol.

Although the program manager stated that compliance officers' visits to participants generally should not be made at diversion group meetings, there is no written policy pertaining to this issue. In fact, our review of the participants' case files revealed that 14 visits were made by compliance officers to participants at diversion group meetings. In these cases, the compliance officers wrote reports documenting these visits for participants' case files. One-half of all the reports one compliance officer wrote to document visits to participants in our sample were for contacts made with the participants at diversion group meetings or for telephone calls the compliance officer made to participants. When compliance officers visit participants primarily at diversion group meetings, they are duplicating the monitoring duties the facilitator performs, and they are not visiting the participants on an unscheduled basis to ensure that participants comply with their treatment plans.

Compliance Officers Do Not Collect Urine Samples as Frequently as Policy Requires

Compliance officers also are not collecting all the required urine samples. The board's written policy states that compliance officers are required to collect a urine sample from each participant at least once every month until the participant abstains from the use of alcohol and drugs for one year. Once the participant has abstained from drugs or alcohol for one year, a urine sample is required only once every two months. In addition, compliance officers should collect

urine samples more frequently than once a month from participants who are using, or who are suspected of using, drugs or alcohol.

Fourteen of the 21 participants in our sample were required to have urine samples collected monthly; however, as Table 2 indicates, compliance officers did not collect the required urine samples from 10 (71 percent) of these 14 participants.

TABLE 2

URINE SAMPLES COLLECTED BY COMPLIANCE OFFICERS FROM PARTICIPANTS

Number of Months With No Urine Sample	Number of Participants	Percent
1	4	29%
2	5	36
3	3	21
4	2	14
Total	14	100%

Table 2 shows that compliance officers did not collect urine samples from 10 participants for periods ranging from approximately two to four months. In addition, 2 of these participants were using, or suspected of using, drugs or alcohol; however, the compliance officer did not increase the frequency of collecting urine samples from these participants. For example, the compliance officer collected a urine sample from one participant 11 days after the participant admitted using alcohol; however, the compliance officer did not collect another urine sample from the same participant for two and one-half months.

Moreover, 9 of the 14 participants in our sample who required monthly urine samples had been participants in the program for less than one year. Although, according to the board, participants are most likely to use drugs or alcohol during their first year in the program, compliance officers did not collect the required monthly urine samples from 7 (78 percent) of the 9 new participants in our sample. One compliance officer had not collected any urine samples from 2 participants between the time the participants entered the program in mid-November 1985 and the end of our review, February 28, 1986. Consequently, the compliance officer did not collect urine samples for these new participants for at least three and one-half months.

In January 1986, the program manager implemented a new policy regarding urine sampling. Because compliance officers are no longer required to visit all participants monthly, the compliance officers will ask facilitators to obtain urine samples from those participants whom compliance officers are unable to visit during a given month.

Compliance Officers Do Not Maintain Adequate Contact With Participants' Condition Monitors

In addition to not collecting the required urine samples, compliance officers are not contacting participants' condition monitors often enough. Participants whose treatment plans require condition monitors must obtain condition monitors within ten days of entering the diversion program. Compliance officers should contact condition

monitors within the first month that participants sign their treatment plans. During this initial contact, the compliance officers should provide the condition monitors with a letter outlining condition monitors' responsibilities, explain each of these responsibilities to the condition monitors, and have them sign the letters to acknowledge their agreement to carry out these responsibilities. After this initial contact, compliance officers are required to contact condition monitors either in person or by telephone at least every two months.

Fifteen of the 21 participants in our sample were required to have a condition monitor. Fourteen of the 15 participants have condition monitors; however, one participant never obtained a condition monitor. Although this participant had been in the program for almost three and one-half months at the time our review ended, there is no evidence in his file to show that he obtained a condition monitor. In addition, there is no evidence that the compliance officer ever attempted to identify or contact the participant's condition monitor.

Furthermore, Table 3 shows that 12 (86 percent) of the 14 condition monitors assigned to participants were not contacted by compliance officers as often as policy requires.

TABLE 3

VISITS COMPLIANCE OFFICERS MADE TO CONDITION MONITORS

Number of Months Compliance Officers Did Not Contact Condition Monitors	Number of Condition Monitors	Percent
0 - 2	2	14%
3	5	36
4	1	7
5	1	7
6	1	7
7	3	22
8	1	7
Total	14	100%

As illustrated in Table 3, contacts were not made with 12 of the 14 condition monitors for periods ranging from three to eight months. In one case, at the time our review ended, a compliance officer had not contacted a participant's condition monitor although the participant was required to obtain a condition monitor eight months earlier. In addition, 8 of the 14 participants who had condition monitors entered the program after July 1, 1985. Compliance officers did not contact these new condition monitors as frequently as required in 7 of these 8 cases (88 percent). Although the board's policy states that condition monitors should initially be contacted within the participant's first month in the program, condition monitors of 3 participants who entered the program after July 1985 and were assigned to the same compliance officer had still not been contacted at the time our review ended. These participants had been in the program for periods of at least six months.

In addition to not maintaining adequate contact with condition monitors, compliance officers are not ensuring that condition monitors sign and submit the letters that explain the condition monitors' responsibilities. Only 4 (29 percent) of the 14 condition monitors signed and submitted these letters. If compliance officers do not maintain contact with condition monitors and if they do not require condition monitors to sign and submit letters indicating that condition monitors understand their responsibilities, the diversion program cannot ensure that condition monitors fully understand their role or that participants are being monitored while they practice medicine.

Decreased Opportunities To Detect Alcohol and Drug Abuse

Eight (38 percent) of the participants in our sample were not adequately monitored in any of the three areas we have discussed: compliance officers did not visit these participants frequently enough, compliance officers did not collect required urine samples, and compliance officers did not maintain adequate contact with these participants' condition monitors. In cases such as these, the board is not protecting the safety of the public as effectively as it could be because compliance officers have fewer opportunities to identify physicians who continue to use drugs or alcohol while in the diversion program.

Two cases from our sample illustrate the effectiveness of appropriate monitoring in detecting the use of drugs or alcohol. In

one case, a compliance officer suspected a participant of using drugs and, in accordance with program policy, she collected urine samples more frequently from the participant. One of the urine samples indicated that the participant had used marijuana, so a diversion evaluation committee directed the participant to enter a live-in program that provides treatment for persons who suffer from drug abuse. In another instance, a compliance officer who maintained appropriate contact with a condition monitor was told by the condition monitor that a participant was conducting questionable office practices. The compliance officer reported this conduct to the program manager. Then the participant was reviewed at a diversion evaluation committee meeting. When the participant admitted using alcohol, the diversion evaluation committee directed the participant to enter a residential facility that provides treatment for persons who suffer from alcoholism or drug abuse. In these cases, appropriate monitoring was essential in detecting participants' alcoholism and drug abuse. Appropriate monitoring in all cases could increase the program's opportunities for identifying participants who are using drugs or alcohol.

Limited Supervision

Deficiencies persist in compliance officers' performance because supervision of the monitoring activities of compliance officers has been limited. For example, the program manager does not check the accuracy of compliance officers' recordkeeping. He does not check to ensure that compliance officers always obtain signed letters from

condition monitors explaining the condition monitors' responsibilities. The program manager also does not ensure that visits to participants recorded by compliance officers on their monthly logs are documented in writing. Nor does he ensure that urine samples that compliance officers report they have collected are documented by laboratory reports. Because the program manager does not check the accuracy of compliance officers' recordkeeping, deficiencies in the work of a specific compliance officer may not always be noted.

In addition, the program manager does not have a system to routinely produce and follow up on specific reports identifying those participants whom compliance officers have not visited frequently enough, who have not had required urine samples collected, and whose condition monitors have not been contacted. Although the program manager has, on occasion, compiled lists for compliance officers of those participants who have not been adequately monitored, these lists have been sporadic, and there is no evidence that the program manager has followed up on these lists to ensure that the compliance officers have taken appropriate corrective action. In May 1986, the program manager began implementing a computerized tracking system which will produce information that identifies participants who are inadequately monitored. The program manager states that he will use this system to monitor the performance of compliance officers.

The program manager also stated that deficiencies in monitoring participants have occurred because of personnel problems.

He believes that certain compliance officers are responsible for a majority of the deficiencies we identified. In fact, the program manager dismissed one compliance officer for neglecting duties. In July 1985, the program manager began disciplinary action against this compliance officer, who was officially dismissed on March 19, 1986. A new compliance officer joined the diversion program on April 8, 1986. The program manager stated that he will continue to take whatever personnel action is necessary to ensure that board policies are followed.

CONCLUSION

The Board of Medical Quality Assurance has improved some elements of its diversion program for physicians; however, further improvement is needed. Since 1985, the board has improved its procedures for reviewing participants who do not comply with the significant terms and conditions of their treatment plans. The board has also improved its overall supervision of the diversion program. However, the board still does not routinely monitor physicians in the diversion program adequately.

Of the 21 participants in our sample, compliance officers did not visit 17 (81 percent) of the participants at least every two months as they should have. Some participants were not visited for up to seven months. Compliance officers also did

not collect all urine samples for 10 of the 14 (71 percent) participants in our sample who required urine samples monthly. These urine samples were not collected for up to four months. In addition, compliance officers did not contact participants' condition monitors as frequently as required. As a result of inadequate monitoring, the board has decreased its opportunities for identifying physicians who continue to use drugs and alcohol while in the diversion program.

RECOMMENDATIONS

To improve the monitoring activities of its compliance officers, the Board of Medical Quality Assurance should do the following:

- Ensure that compliance officers understand current program policy and know how to keep accurate records; and

- Clarify written program policy to state that the majority of compliance officers' visits to participants should not be at diversion group meetings.

To improve the supervision of compliance officers' monitoring of participants, the Board of Medical Quality Assurance should do the following:

- Develop a system to verify the accuracy of compliance officers' recordkeeping. This system should include a method for cross-checking monthly logs of compliance officers' activities with supporting documentation such as reports compliance officers write for participants' files, laboratory urine analysis reports, and letters condition monitors sign during an initial visit; and

- Follow through in using its computerized tracking system to routinely identify deficiencies in compliance officers' monitoring of participants. This information should be used to ensure that compliance officers take the action necessary to correct deficiencies.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

for THOMAS W. HAYES
Auditor General

Date: June 16, 1986

Staff: Robert E. Christophel, Audit Manager
Janice Shobar Simoni
Mark T. Wallace

APPENDIX A

STATUS OF ALL PARTICIPANTS IN THE DIVERSION PROGRAM SINCE ITS INCEPTION AS OF MAY 1, 1986

Participant Status	Number	Percent
Currently Active Participants		
Drug abuse	106	48.6%
Alcohol abuse	50	22.9
Alcohol and drug abuse	30	13.8
Mental illness	14	6.4
Mental illness and substance abuse	17	7.8
Physical illness	0	0.0
Physical illness and substance abuse	1	0.5
Total	218	100.0%
Successfully Terminated Participants		
Drug abuse	46	43.8%
Alcohol abuse	28	26.6
Alcohol and drug abuse	12	11.4
Mental illness	7	6.7
Mental illness and substance abuse	10	9.5
Physical illness	1	1.0
Physical illness and substance abuse	1	1.0
Total	105	100.0%
Other Terminations From Program		
Deceased	10	14.7%
Moved out of state	17	25.0
Put on probation	2	2.9
Revoked license	1	1.5
Surrendered license	2	2.9
Requested termination	17	25.0
Did not comply with program	19	28.0
Total	68	100.0%

APPENDIX B

STATUS OF DIVERSION PROGRAM PARTICIPANTS INCLUDED IN THE AUDITOR GENERAL'S 1985 REPORT*

Participant Status	Number	Percent
Still in diversion program	24	68.5%
Successfully terminated from program	9	25.7
Unsuccessfully terminated from program due to noncompliance	1	2.9
Moved out of state	1	2.9
Total	35	100.0%

*In our January 1985 report entitled "The State's Diversion Programs Do Not Adequately Protect the Public From Health Professionals Who Suffer From Alcoholism or Drug Abuse," P-425, we reviewed the case files for 35 participants; this table shows the status of these participants as of February 28, 1986.

GEORGE DEUKMEJIAN, GOVERNOR

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State and Consumer Services Agency

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June 9, 1986

Mr. Thomas W. Hayes
Auditor General
Office of the Auditor General
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Sacramento, CA 95814

Dear Mr. Hayes:

Thank you for your letter of June 2, 1986 requesting my comments on your draft report (P-576) concerning the Diversion Program of the Board of Medical Quality Assurance. I have discussed the issues raised in your report with representatives of the Department of Consumer Affairs, as well as the Board, and am pleased to have this opportunity to express my viewpoint.

At the outset, let me state that we concur with the findings and recommendations of the audit report. The draft recommendations are now being implemented and complete implementation will be achieved prior to the report being published .

The audit reviewed the case files of selected participants from July 1985 to February 1986. This period directly coincided with the first eight months of the new program manager's time with the Board. During this time, many positive changes were being implemented. Many of these changes were occurring at the very time that the auditors were in the program office. Other significant changes were not effective until the last few weeks. Our comments on the specific findings and recommendations are as follows:

The Board will continue frequent training meetings with the compliance officers to make certain that Board policy is followed. These training sessions will include reviews of procedures and policies. It will also include a review of each compliance officer's contact with participants and urine samples taken. As a part of this review, the compliance officers were informed in writing on April 16, 1986 that contacts with participants at group meetings will not constitute personal contacts

In addition, the system of processing participant information has been strengthened so that the information on compliance officer's report is verified. A system has been adopted to verify that urine samples are being taken from each participant each month. This is being done by comparing a monthly report of all urine tests from the lab to a list of participants in the program. Also, the need to verify the information on compliance officer contact reports with the information in the computer has been eliminated by combining two report forms. The verification that compliance officers have contacted and briefed condition monitors of their duties will be performed during a monthly review with the compliance officer.

Further, the new computerized participant profile and tracking system will produce an exception report for each compliance officer showing which participants have not been contacted timely, which monitors have not been contacted timely, which participants have not had urine samples taken, and which participants are not complying with their diversion agreements. The report will be discussed with each compliance officer monthly, or more frequently if necessary. Appropriate action will be taken where contacts are not being made or urine samples not being taken. The first review of prior month's activities will occur during the second week of June.

While we fully support the program adjustments discussed above, I must note that the Board has adopted a number of significant new policies during the last year to strengthen the monitoring of physicians and to protect the public safety. While such improvements were not specifically referenced in your report, we trust that you are familiar with them.

Thank you, again, for the opportunity to comment. It is only through constructive review of programs that the citizens of California can be assured of effective and efficient activity by government. With that in mind, your continued efforts are appreciated.

Sincerely,

SHIRLEY R. CHILTON
Secretary of the Agency

SRC:TC:jy

Attachment

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE
SACRAMENTO, CA 95825

TO: Thomas W. Hayes
Auditor General

DATE: June 5, 1986

VIA: Shirley Chilton, Secretary
State and Consumer Services Agency

VIA: Marie Shibuya-Snell
Director
Department of Consumer Affairs

SUBJECT: Response to Audit of BMQA's Diversion Program

We welcome the opportunity to comment on the audit performed by the staff of the Auditor General's office.

As in past reviews, we found that the staff of the Auditor General's office conducted themselves with great professionalism, and the audit process and findings have been of assistance to the program manager.

We concur with the findings and recommendations of the audit report and in fact have already implemented all of the recommendations. On the other hand, it is somewhat unfortunate that the audit approached our program solely from the perspective of how well our monitoring system is operating. We say unfortunate, first, because we believe the monitoring system in BMQA's Diversion Program is far more extensively developed, with greater checks and balances, than any other publicly or privately run program of this type of which we are aware. The standard we are being held to is therefore unique among programs of this type.

Second, and more important, the approach of an audit of this nature results in little attention being given to the accomplishments of the program, and to the many positive changes in policy and operations which are not directly related to monitoring, but which in the long run have just as profound an affect on the public protection afforded by Diversion.

In our comments, therefore, I would like to first address the specific recommendations made by the report, and follow with a discussion of important aspects of the program which were not covered by this audit. These aspects, we believe, are critical to a fair and balanced understanding and appraisal of the BMQA Diversion Program. In some cases, they have been implemented in response to your earlier reviews.

RESPONSE TO RECOMMENDATIONS AND FINDINGS

The audit reviewed the case files of selected participants from July 1985 to February 1986. This period directly coincided with the first 8 months of the new program manager's time with the Board. During this time, many positive changes were being implemented. Many of these changes were occurring at the very time that the auditors were in the Program office. Other significant changes were not effective until the last few weeks. Our comments on the specific findings and recommendations are as follows:

1. All the recommendations of the Auditor General will be implemented by by the time this report is published.

   First, we will continue frequent training meetings with the compliance officers to make certain that Board policy is followed. These training sessions will include reviews of procedures and policies. It will also include a review of each compliance officer's contact with participants and urine samples taken. Second, and as a part of this review, the compliance officers were informed in writing on April 16, 1986, that contacts with participants at group meetings do not count as personal contacts.

   Third, the system of processing participant information has been strengthened so that the information on compliance officer's reports is verified. A system has been adopted to verify that urine samples are being taken from each participant each month. This is being done by comparing a monthly report of all urine tests from the lab to a list of participants in the program. Also, the need to verify the information on compliance officer contact reports with the information in the computer has been eliminated by combining two report forms. The verification that compliance officers have contacted and briefed condition monitors of their duties will be performed during a monthly review with the compliance officer.

   Fourth, the new computerized participant profile and tracking system will produce an exception report for each compliance officer showing which participants have not been contacted timely; which monitors have not been contacted timely; which participants have not had urine samples taken and which participants are not complying with their diversion agreements. This report will be discussed with each compliance officer monthly, or more frequently if necessary. Appropriate action will be taken where contacts are not being made or urine samples not being taken. The first review of prior months' activities will occur during the second week of June.

2. The cases reviewed in the audit do not, we believe, reflect the current monitoring activities or the performance of all compliance officers.

   We have only four compliance officer positions statewide. The overwhelming majority of the problem cases identified in the audit were in the caseloads of particular compliance officers. Our review shows that the other compliance officers were and are doing an adequate job of monitoring participants. Two out of the four compliance officers whose cases were audited are no longer employed by the BMQA, and as noted in the report, one was fired by the Board for dereliction of duty. Not only is current staff performing well, but new policies to strengthen the supervision of compliance officers were instituted during the latter part of the audit period. As the audit report indicates, we will continue to take strong action to ensure that program policies are being followed by staff.

PROGRAM ENHANCEMENTS NOT SUBJECT TO AUDIT

We do not believe the audit gives enough recognition to the new policies adopted by the Division of Medical Quality (DMQ) during the last year to strenthen the monitoring of physicians and to protect the public safety. These policies were in part a response to criticisms leveled by the Auditor General last year that the DMQ was not taking sufficient responsibility for overseeing the program. The most important of these new policies adopted by the DMQ were the following:

1. Physicians who have privileges in a hospital must have a physician monitor at each hospital. All participants with hospital privileges must initially identify themselves as Diversion Program participants to the hospital's physicians' aid committee, chief of staff, or the hospital administrator.

2. Physicians who are unsuccessfully terminated from the program will have their record in the Diversion Program turned over to the Board's Enforcement Program if it is determined that they will not be able to practice medicine safely.

3. All physician participants, including non-Board referred physicians who unsuccessfully terminate from the program, will be reported to the chief of staff or the hospital administrator where the physician has privileges.

4. Physicians on probation to the Board who have abused alcohol or drugs are now allowed to enter the Diversion Program. This places greater monitoring requirements on the probationer and strenthens the physician's recovery.

We also believe that the Audit report does not give recognition to such positive developments as the recently initiated periodic reviews of participants' rehabilitation progress and compliance with Diversion agreements. All participants in the program are now periodically reviewed to make certain that they are moving toward recovery and are complying with their Diversion Agreements. These periodic reviews are made by the compliance officer, the Sacramento Diversion staff, the DEC committees and the facilitators. In the last six months, the DEC committees have reviewed in person about 39 participants' recovery programs and have made a case file review of about 60 participants.

THE "BOTTOM LINE": PUBLIC PROTECTION AND ACCOMPLISHMENTS

In concentrating solely on the monitoring function, we believe one can lose sight of the uniqueness and true accomplishments of the BMQA Diversion Program. To the best of our knowledge, there is no other alcohol and drug rehabilitation program which so intensively monitors its participants for such an extended period of time, two to five years. Most alcohol or drug rehabilitation programs generally require 30 days participation in an inpatient program or one years participation in an outpatient program. The long period of monitoring by the Diversion Program offers protection to the public as the physician is recovering. Secondly, none of the diversion programs operated by the other licensing boards even have compliance officers for monitoring participants. To a certain extent, the BMQA Diversion Program is being measured against a yardstick that is taller than anyone else's.

Finally, when all is said and done, we believe strongly that the Diversion Program is a success and is accomplishing what it was established to do. About 59% of the physicians who enter the program complete it successfully. When a physician successfully completes the Diversion Program, the physician has demonstrated that he or she can remain alcohol or drug free for a minimum of two years. The physician has also proven to the DEC members that there have been internal changes in the physician's attitude and lifestyle. We believe this new attitude and lifestyle makes the physician a better person and a better practicing physician.

Since the program began in 1980, 105 physicians have successfully completed the program. This means there are 105 physicians who did not require formal discipline who are now practicing medicine safely. The monetary and human benefit of this is much greater than the cost and time to train a new physician to enter the profession.

Kenneth J. Wagstaff
Executive Director

KJW:CP:ru

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps